incentivized and given unfair advantage over rail transit, and I would like to see them compete on equal footing.

So let me say, don't be afraid of the future. The future is coming anyway. Those who stand up and say, Well, we can't have a bill that's going to help America get off fossil fuels and cut greenhouse gas emissions because it's nothing but a tax, understand that the folks who told you about tax-and-spend liberals and all of that—look, we've only had a President and a Democratic Congress for a few months. This stuff wasn't inherited. You want to talk about spenders and debt accumulators? Those guys sit on the other side of this Chamber.

□ 1830

The fact is, the progressive future this country needs is in the hands of the people who are going to help America get into a green, clean future.

This bill, this ACES bill that is being marked up right now, that has already gone through Energy and Commerce, that is in the Agriculture Committee now. This bill is undone and needs the input of all America, people who have a progressive vision for America, people who aren't afraid of the future, not people who cling to the status quo and what happened yesterday, but people who want something better for tomorrow and are willing and have the courage to try to get it.

That's the Progressive Message for tonight. I want to thank everybody for tuning in.

Mr. Speaker, I yield back.

HEALTHCARE REFORM

The SPEAKER pro tempore (Mr. MINNICK). Under the Speaker's announced policy of January 6, 2009, the gentleman from Illinois (Mr. KIRK) is recognized for 60 minutes as the designee of the minority leader.

Mr. KIRK. Mr. Speaker, tonight, what we would like to talk about is a new and positive medical reform agenda as Congress prepares to debate health care in the United States.

I want to focus this discussion on what we should be for—a bipartisan and centrist agenda for the United States—and compare our country to plans in other countries to make sure that we take the best of all medical care around the world but don't replicate some of the problems that we see both here and abroad.

When we look at a comprehensive reform agenda that would receive widespread support both in the House of Representatives and the Senate, we basically unify around eight major themes.

First, we want to make sure that we guarantee that medical decisions are kept in the hands of patients and their doctors and not a new government bureaucracy.

Second, we want to lower the cost of insurance to make sure that the competitive advantage that the United States could enjoy would be realized, and that also individual costs for all American families are lowered.

We want to increase the number of Americans who have health insurance to make sure that more and more families have the peace of mind that they need to protect their family incomes, their health, and most importantly, their lives.

We want to allow Americans to keep the insurance they like because we know that over 80 percent of Americans—and especially voters—report that they are either satisfied or extremely satisfied with the health insurance plan they have.

And we want to make sure that we replicate the doctor's principle, that first we should do no harm. And in the Congress, on health care policy, we should follow that advice.

Fifth, we would like to improve quality and accountability and make sure that especially the cost of defensive medicine is reduced and that we know exactly what we are doing with regard to health care outcomes to make sure that we are maximizing the treatment and cures provided when a patient presents in a health care facility.

We want to increase personal responsibility, especially for many of the decisions Americans are making because we know that if they lose weight, quit smoking, and stop drinking, their health care will improve dramatically.

And, finally, we want to lower demand for more Federal borrowing at a time when the United States is already reporting that it will borrow $1.8 trillion this year. It is difficult to argue that we should turn every family's health care over to the Federal Government, an institution which is already, as the President says, ''out of money.''

When we look at health care across the world, we see that the percentage of patients who wait more than 2 months to see a specialist is not a dramatic issue in the United States, but this is front-page news in both Canada and the United Kingdom. According to the Commonwealth Fund International Health Policy Survey of Sicker Adults, they report that about 10 percent of Americans wait more than 2 months to see a specialist, but one-third of Britons do, and approaching half of Canadians wait a long time for health care.

We know that health care delayed is health care denied. And imagine—especially if the specialist that you need is an oncologist, someone who treats cancer—what a 42-week wait would be as compared to what we see in the United States.

Secondly, we know from asking Americans, What is the most important thing you would like to see in health care?, they say lowering the cost of their health insurance. Many in this body also say the number one priority is to expand health care coverage so that Americans who do not have health insurance can get it. I would say those two goals are very important, but the most important goal of health care is to determine whether you live or die, to make sure that, especially if you are facing health care challenges of the most severe degree, you have the greatest chance for you or a member of your family to survive. This is most clear in the case of cancer.

When you or I or a member of our family gets that terrible diagnosis from a doctor that you will be fighting cancer, the question is often asked, How much time do I have? Will I be able to survive? When we look at The Lancet, Britain's number one medical journal, they did a ground-breaking study of cancer survival rates across Europe, Canada, and the United States and found that you are more likely to survive in the United States than you are in especially European countries.

They looked at a number of different cancers. For example, prostate cancer: a 78 percent survival rate in Europe—which is fairly good—but a 99 percent survival rate if found in the United States. Bladder cancer: only 66 percent of Europeans survive bladder cancer, 81 percent of Americans. Breast cancer: 79 percent of Europeans will survive breast cancer, but 90 percent of Americans. And uterine cancer: 78 percent of Europeans will survive, but 82 percent of Americans.

Why is it that Americans are doing so much better against cancer than Europeans? Part of it is because in Canada and Europe advanced oncology medicines to fight cancer are restricted; and especially imagery to find cancer, either through x rays, MRIs or CAT scans, are much more available in the United States to find cancer, especially at its earlier stage, which means that Americans, bottom line, have a greater chance of surviving cancer than Europeans.

When we look at 5-year survival rates, overall the picture is also stark. Women fighting cancer have a 63 percent chance of surviving if they are treated in the United States. That survival rate drops to just 56 percent in Europe. For men, the difference is even starker. Sixty-six percent of American men will survive a cancer diagnosis, only 47 percent of European men.

Bottom line, once again we see, across both men and women, you are much more likely to survive cancer in the United States than in European countries. And much of the reason why is because in countries in which the government controls more of the health care sector, they restrict access to oncology medicine and to imagery. That means that cancer is found later and is fought with less aggressive drugs, meaning that Europeans will die at a higher rate than Americans.

When we look at high-tech medical procedures in Britain, Canada, and the United States, many people would say that health care costs are derived by too much access to high-tech medical care. But what we see here is that survival rates are higher in the United States, meaning high-tech is good. And

the chance of your family member surviving improves when you have access to oncology medicine and MRIs.

We see the differences between Britain, Canada, and the United States most clearly here where Britain, who has had the longest record of socialized government-controlled medicine, has very low rates of providing dialysis care as opposed to the United States. In coronary bypass, we see even Canadian rates are much lower. And especially in coronary angioplasty, the United States far outdistances countries with socialized medicine, leading to higher survival rates and better outcomes for Americans over patients who face socialized medicine.

When we look at quality outcomes, this is another study showing the amount of time that you have to wait to see a specialist doctor. In this Commonwealth study, they rated the percentage of people that had to wait more than 4 weeks to see a specialist doctor. This is not a critical issue in the United States, but once again, front page news in the U.K. where we see the rate of patients that have to wait and, therefore, are denied care is three times the rate of the U.S. rate in Canada and in the United Kingdom as opposed to the U.S. And only Germany has a level somewhat equaling the U.S. record of getting you to see the specialist you need when you need to see it without a wait.

This is another chart which shows patients having very long waits. We see that in the United States, only 8 percent of Americans have to wait more than 4 months to see a key specialist, but 41 percent of people in Britain. Imagine getting a diagnosis of cancer, knowing that it is in your body, and being told that you had to wait more than 4 months before you could even see the specialist that you need to survive. This is why we are quite worried about the restrictions that would be caused and denial of care in a socialized system.

Remember also that since the U.S. Government is $1.8 trillion in debt just this year, if you give control of your health care to the government and the government is already out of money, how will it try to save money to rectify the deficit? If it's in control of your health care, it may do what the Canadians and Britons do, which is control your access to care.

I am very happy to be joined by my co-Chair of The Tuesday Group, Congressman DENT from Pennsylvania, who has been a leader on health care and has engaged in a number of these international comparisons.

Mr. DENT. Thank you, Congressman KIRK, for your leadership on health care. As you know, we have been working diligently to come up with some alternative ideas. And the chart that you have just identified in terms of cancer survivability rates as well as health care costs, I think really drives home the point that Americans all across this country understand: that we have a health care crisis, we particularly have a crisis in cost. And they understand, too, that depending on how we engage in health care reform could impact the care they receive.

Americans are concerned about medical breakthroughs, innovation, and quality. They're also concerned about the ability to get the care they need when they need it because they understand that if care is delayed, care is denied.

And you pointed out some interesting cancer survivability statistics from Canada. Interestingly enough, an anecdote: there is a member of Parliament in Canada, I believe she was a member of the Liberal Party. She is a great proponent of the Canadian health care system. And what happened is that she contracted breast cancer, and for whatever reason, she decided she needed her care in the United States. It created quite a controversy in Canada because it really spoke to the issue in Canada, which was that the Canadian system was good enough for all the Canadians, but not for this particular member of Parliament. And it spoke to the issue of two tiers of system, one for those who are in Canada, and those who, when they can't get the care that they need when they need it, they simply go south—because much of the Canadian population lives within 50 miles of the American border. So the second tier of Canadian health care can be provided across the border, and people pay top dollar.

So I think that's something that we have to talk about quite a bit as we engage in this discussion: that we understand that care delayed is care denied, that people understand that the costs are rising, and that we have to come up with solutions.

I am going to be, at some point tonight, talking about medical liability reform, why we need that. And that is a major cost driver. Defensive medicine costs have gone up significantly because of the tort system in the United States. We understand that there is just too much money being spent in the courtroom and not in the operating room. I think we all understand that.

We are also joined tonight by our friend and colleague from western Pennsylvania, TIM MURPHY, Dr. MURPHY, who has a background in psychology, and also has a great deal of interest on this issue.

At this time, I would be happy to yield to my friend and colleague from western Pennsylvania.

Mr. TIM MURPHY of Pennsylvania. I thank my friend from Pennsylvania and also thank Congressman KIRK of Illinois for putting together this important session tonight to talk about health care.

One of the concerns that comes up repeatedly when you talk about health care is the cost. And one of the things that happens, as Washington deals with it, is two approaches: one, they say health care is expensive, let's have the government pay for it, which means you raise taxes. And the other one they say, health care is expensive, let's deal with insurance issues, perhaps some tax credits, which means it's still taxes that pay for it. And I understand in both cases we are trying to lower health care cost, but neither one really gets to the root of that, and that is, dealing with some of the issues that have to do with improving the quality of health care to make it more affordable and accessible. So I would like to focus a little bit on some comments tonight that specifically address this issue of how we lower health care costs.

As part of the plan that Congressman KIRK and Congressman DENT have led here for our group in coming up with some cost savings in health care, one of them has to do with trying to make sure we are providing health care to those who are not able to afford it. We know that currently the government provides assistance for those who have a low income through Medicaid, for the elderly through Medicare, for veterans through the VA; but for those just above the level of Medicaid income, that's the group that we are really deeply concerned about because we want to make sure they get the care they need.

□ 1845

One thing that's also important then is to make sure they have a health care home. Those who have a doctor or a specialist they can go to when they have an illness are much more likely to have that illness treated in a timely manner to provide a cure for them. Care delayed, care denied. When we look at how Medicaid and Medicare operate, that it really sometimes takes an act of Congress to get something done, that's care delayed. Let me give you a couple of examples about how there are problems with that. Let's say you have a stroke and an ambulance takes you to a suburban hospital. Sometimes those hospitals do not have a neurologist. Many times they don't have a neurologist on staff 24/7 or a radiologist. So what happens? Wouldn't it be great—imagine a world whereby a neurologist, through telemedicine, for example, could connect up with the patient, looking at them on a video camera, the patient seeing the doctor. That doctor could be half a country away or could be 20 miles away, whatever it may be, doing the exam with the assistance of a nurse on site. Look at the signs, look at the way the patient responds, and be able to diagnose and offer, does that patient get one type of treatment, which is if there are blocked arteries in the brain leading to the stroke, or another type of treatment which might be hemorrhagic, that is, a burst artery. Each one critically different life-saving treatments. It could mean the difference between the patient who lives and dies. Also it could make a difference between the patient who has years and years of physical therapy, occupational therapy, and speech therapy or one who has

a shorter recovery time. Because when you have a stroke, time is brain. That would make sense if we imagined that, but Medicare doesn't cover that. Instead, it's going to take an act in Congress—I know our friend and colleague Lois Capps from California has been pushing a bill for a while to allow Medicare to do that. This is not a new idea, but we have to take an act of Congress to do this. Or how about this—if you are going to get something called home infusion therapy to provide an IV line, to provide some medical treatments to you, you could do that at home, in many cases, with insurance companies, but not necessarily with Medicare and Medicaid because they want you to go to hospital where you have to go all the way to the hospital, and your risk for problems could increase. It's also going to take an act of Congress to make it so that hospitals actually have to state what their infection and complication rates are. I always find it amazing, you can go online and you can find out, if you are shopping for a new car, everything about that car. You want to shop for clothes, you can go all over the place, checking out the quality reports, consumer reports, all those things on that. If you want to look up the records on a hospital, am I more likely to get sicker or better when I am there, you can't find out that information. As my friends know, for a number of years I put forth a bill to provide transparency in this area, whereby you could look up and find out the infection rate of a hospital. This is critically important because nosocomial infections, that is infections you pick up in a hospital or clinic, kill 100,000 people each year, cost $50 billion, and there are 2 million cases. Sadly, Senator BYRD, one of our colleagues in Congress, is right now suffering a staph infection; and many of our colleagues have had a family member who has faced the same problem. It would be nice to know, and the advantage of having that information out there is that you can look it up, and you could find out. Hospitals that have paid attention to this have actually reduced some of their infection rates to near zero. That's what we want to see, but it's going to take an act of Congress to change that.

Mr. KIRK. I think one of the key lessons that we want is, we want Americans to have health insurance as good as a Congressman, but we don't want them to have to call their Congressman to get good health care. One of the things that we've also seen is that the United States really stands out in a couple of areas that drive health care costs up. We have very little to no Federal lawsuit reform in the United States for health care, meaning that defensive medicine is the practice of the day in our country as opposed to other countries because doctors are so likely to be sued. Another is that, yes, Americans generally have a higher degree of obesity as compared to other countries. And so the Congress and the President, on a bipartisan basis I think, will have a lot of common ground in working and encouraging a reduction in weight by Americans because this will lower health care costs. One of our key experts on how lawsuits drive health care costs up is our colleague from Pennsylvania as well, Congressman DENT.

Mr. DENT. I thank the gentleman for yielding. In Pennsylvania, of course, we have been in a crisis state for some time with respect to medical liability. In fact, my colleague Tim Murphy remembers the great debates we had in Pennsylvania about the need for joint and several liability reform, to make sure that the award would be basically proportional to the degree of fault. We felt that that was something that was absolutely essential. Caps on noneconomic damages, another area we were greatly in need of reform in Pennsylvania. Also the notion of a periodic payment as opposed to one big lumpsum award. One could pay those payments out over a period of time. Something that, again, was absolutely essential. In the city of Philadelphia, in particular, we had a very real crisis. In fact, at the time a group called Jury Verdict Research had done a number of studies about the jury awards and settlements coming out of the city of Philadelphia. The average jury award at that time was somewhere around $1 million. The rest of the State, on average, was a bit less than $500,000. In fact, it got so bad one year that there were more awards and payouts out of the city of Philadelphia than in the entire State of California; and the city of Philadelphia has a population of about 1.5 million people. So what we had to do was find ways to get cases out of the city of Philadelphia, out of those courts. So Congressman MURPHY and I actually passed legislation that would have essentially required the cases be heard in the county where the alleged malpractice incident occurred, and we supported it in Harrisburg. So that made complete and total sense. Consequently, we tried to pass it legislatively, but we ended up having the Supreme Court establish a rule to essentially provide that kind of a remedy. What happened is, we saw the number of cases heard in Philadelphia drop dramatically as a result of that. So that was just another example of the problems.

Also, we have many people in this country who must go to an emergency room for care. They go to the emergency room, and oftentimes emergency room physicians and staff are the subject of lawsuits. But those same physicians must provide care under Federal law, something called EMTALA; and essentially what that means is that they must provide care. So I think what we should do is provide medical liability relief to those emergency room physicians by treating them as Federal employees, not that they're going to be on the Federal payroll. But for tort purposes, in the Federal Tort Claims Act, they would be relieved from those types of lawsuits. Because we've had situations across this country where trauma rooms have been forced to close down. It's dramatic. We also had a situation where we met an obstetrician recently from one of the hospitals in the city of Philadelphia who actually said, The only reason why we deliver babies is to train our students. We lose money. There are many doctors who choose not to deliver babies these days because of liability. And in Philadelphia I know one hospital, I think it was Methodist Hospital, stopped delivering babies. One of the teaching institutions only delivers just so that they can train their residents. They lose money, and it's very costly to them. But they do it as a service and as a way of training physicians. But that's a very sad state of affairs when we can't deliver babies because of the high costs.

Mr. KIRK. I think the gentleman's point is well taken, especially in comparing two States and the average premium for health care in these two States. In New Jersey, the average premium totals over $6,000 per person, a State that has very little lawsuit reform; and a number of the other reforms that we are talking about in our reform bill that we will be outlining next Tuesday from the GOP centrists are not there in New Jersey. In California, a number of the successful reforms that we've put forward are there; and the average cost of our premium is just $1,885, meaning that if you back the kind of reforms that will be in the outline bill that we put forward next Tuesday, you can drop the cost of health care by thousands of dollars per patient.

Mr. TIM MURPHY of Pennsylvania. As an important part of this, we're trying to drive the point that the losses themselves do not guarantee quality. But it's quality that is very important. I believe you have a chart up there about some tests and procedures. I wonder if you could explain and comment on them a little bit.

Mr. KIRK. When we're looking at preventive care, which is so essential, in many countries with government-controlled systems, because these systems are generally out of money, as governments generally are, they have restricted access to preventive care. So particularly in a Pap smear and a mammogram, two essential procedures in finding cancer in women early, we see that 89 percent of American women will have had a Pap smear within the last 3 years, but only 77 percent of Britons. In a mammogram as well, American women are 86 percent, whereas women in the United Kingdom are 77 percent. All of these major industrialized powers, allies of the United States, have much lower access to care, even though they have government systems.

Mr. TIM MURPHY of Pennsylvania. That brings up an important point of how in the U.S. system we handle such

things as dealing with breast cancer and cervical cancer. One of the sad stories in this country is, more often than is necessarily believed, the U.S. handles lumps, et cetera, by providing mastectomies to women. Other countries may not do that. In part, it may be that the tests come much lower, are much more difficult to get in other countries; but it also brings up the other point. We need to make sure that physicians are empowered to provide that ongoing primary care so they can monitor the patients, get the tests they need. Unfortunately we have a system that pays for quantity, not quality; that pays for defensive medicine, not really working on prevention.

Let me read you an important quote. This comes from the New Yorker magazine, an article entitled The Cost Conundrum by Atul Gawande. It's about Texas towns. It says that between 2001 and 2005, critically ill Medicare patients received almost 50 percent more specialist visits in McAllen, Texas, than in El Paso and were two-thirds more likely to see 10 or more specialists in a 6-month period. Why? It was a different approach to care and, that is, providing more care, providing more surgical procedures, et cetera, doing more tests that were not necessarily warranted. You have another area, like where the Mayo Clinic is up in Rochester, Minnesota, where that dominates the scene. They have fantastically high levels of all this technological capability and quality; but its Medicare spending is in the lowest 15 percent in the country, $6,000 per enrollee in 2006, which is $8,000 less than the figure from McAllen, Texas. I bring that up to say that in the U.S., it is a part of what you are describing that patients need access to these tests in a timely manner, number one; but number two, we also need to make sure the physicians and nurses and all medical specialists are getting the information they need to make sure the quality is what we're driving here. When you are dealing with just issues of insurance or just issues of defensive medicine, you are not necessarily driving quality. You are driving more tests.

Mr. KIRK. One of the other things that we've been concerned about is the increasing price of medical malpractice insurance in the United States. Especially if you look between 2000 and 2002 for obstetricians and gynecologists, for physicians, for internists in general, you've got an explosion in the cost of buying insurance. We do not have 30 percent more malpractice in America in just 2 years, but what we may have is a 30 percent greater chance of being sued in America, the most litigious society on earth. All of this drives health care costs up, as physicians have to cover the cost of malpractice insurance and, of course, over-prescribe tests and other procedures.

Mr. DENT. I would like to get in a few statistics about this. This is a very interesting and pertinent subject, this whole discussion of the cost of health care and why it's rising. Defensive medicine costs the U.S. as much as $126 billion per year. That was out of a 2003 HHS study. One-third of the orthopedists, obstetricians, trauma surgeons, emergency room doctors and plastic surgeons can expect to be sued in any given year. The data for 2006 shows 71 percent of the medical liability cases are dropped or dismissed. Only 1 percent of the cases result in a verdict.

Mr. KIRK. So 71 percent are dropped, but a payment is still made because it's a settlement, and that's going to drive up insurance rates anyway.

Mr. DENT. And the physicians and hospitals have to hire attorneys to defend themselves. So there's a lot of time, effort and money expended just to prepare and fight this battle, only to have it dropped. So there is still a cost incurred even though the case is dropped.

Mr. TIM MURPHY of Pennsylvania. Another issue with regard to this bill we've introduced has to do with allowing doctors to volunteer their services. And here is something that only the United States would mess up in our government. Community health centers, which provide great health care at home for people with lots of different services from primary medical care, dental, mental health, pediatric care, et cetera. But they are strapped for money. In many cases they have a 15 to 20 percent shortage of family physicians, OB/GYNs, et cetera. The doctors are covered under the Federal Tort Claims Act. The Federal Government handles their malpractice at a lower cost for them. But if a doctor wants to volunteer, they're not covered. Basically if a doctor says, I would like to give my time to work a couple days a month, offer my time on a volunteer basis, the clinic has to turn them away because they cannot afford the full price of their malpractice insurance. It is the opposite in a free clinic, where if a doctor is paid, they have to cover their own insurance. But if they volunteer, they are covered under the Federal Tort Claims Act.

We have a bill we've been trying to get in for a number of years to allow doctors to volunteer. The advantages people have at health care home, it is a much lower cost. It even reduces the cost for Medicaid patients to go there by some 30 percent, and it focuses on getting the doctor near the patient and the patient near the doctor and eliminating any incentive of defensive medicine, any incentive to do lots and lots of tests just to make up for the losses.

Mr. DENT. Before we get on to our next topic, I just want to mention one thing. What's the point of this whole discussion? I was talking about the rising costs. But in Philadelphia, premiums rose 221 percent for OB/GYNs in the city of Philadelphia. That is between 2000 and 2008. Premiums rose 149 percent for general surgeons in New Jersey. Premiums rose 348 percent for internists in Connecticut over that 2000–2008 period.

Mr. KIRK. But does it mean though that doctors in Connecticut were 300 percent worse 2 years later?

Mr. DENT. Absolutely not.

□ 1900

The point is, this drives up costs, not just in terms of the liability payments that the doctors and the hospitals must incur, and many physicians are now working in hospital-based practices in part because they can't afford liability insurance, so the hospital must pick up that bill and they are struggling to make these payments.

The point is, it raises costs not just for the doctors and the hospitals, but the tests that are going to be prescribed and administered and treatments perhaps proposed just to protect themselves. This will drive costs up. They are protecting themselves against lawsuits.

What is the other issue? Access to care is a consequence, that there will be less access, that doctors won't deliver babies in the city of Philadelphia. That means people don't have access to an OB. That is important. I think that is the point. It drives up costs and it limits access, and Americans want access to health care and need the care when they must get it.

Mr. KIRK. The bill that we are going to be putting forward by the centrists on Tuesday has a number of liability reform provisions authored by Congressman DENT, and community health center and volunteer liability provisions authored by Congressman MURPHY.

One of the things we talk about is access to care. A critical issue coming up is the uninsured. Now, the Census Bureau indicates that there are about 45.7 million, about 46 million people in the country who are lacking insurance. Of those, about 9.5 million are non-citizens, and the question we have to ask is, should we provide taxpayer-funded care to those people who are not legally present in the United States?

About 12 million of the currently uninsured are already eligible for public programs. Because of lifestyle or because of their choice, they haven't even signed up for the health care that the government already will provide them. About 7.3 million have higher incomes than most Americans. They make over $84,000 a year. And about 9 million are only temporarily uninsured.

As you can see here from an older chart showing 49 million uninsured, a large number of the uninsured were uninsured temporarily, only 5 months, and another 25 percent were uninsured for only 6 months, leaving about 53 percent of this cohort uninsured for a long time, a group we all agree should be addressed.

When you take 45.7 million people uninsured, remove the noncitizens, remove the people who haven't signed up for the government programs they have already been eligible for, remove people who have higher incomes than most Americans and should buy it anyway, and remove the temporarily uninsured, you get down to a number of

only 7.8 million. But this might not be a big enough number for a government takeover.

Mr. DENT. If the gentleman will yield, one of the interesting demographics with respect to the uninsured population, I think we really need to focus on this like a laser beam. Over half, I believe, 55 percent of the people lacking coverage in America are under the age of 35. Many of them are insurable. Those college-age kids up to age 35, they tend to be more insurable than much of the rest of the population.

So I believe we do have some suggestions and proposals as a way to cover that population, get them into an affordable catastrophic coverage that they will need in the event that something dramatic happens in their life where they need that kind of coverage. I would like to talk about that a little later. But that is another statistic I don't think we talk enough about.

Also, there are a large number of people uninsured who are currently eligible for programs, whether they be Medicaid or the Children's Health Insurance Program.

Mr. TIM MURPHY of Pennsylvania. If the gentleman will yield. As you know, many of those younger folks you are talking about consider themselves to be the invulnerables. They don't need insurance, they are never going to get sick. The problem becomes one that when they don't do that and they do get sick and they do end up in the emergency room, we pay for it. It is important that we remove any barriers and provide every encouragement and incentive for them to purchase that insurance that many times the employer does offer.

Mr. KIRK. I want to just point out, and I do want to go on to expanding health care insurance, we find for many small businesses they lack health insurance for their employees, and we ought to allow small businesses to join together. For example, the Libertyville Chamber of Commerce Association Health Plan is right now prohibited under Federal law. We should allow small businesses to band together to create large insurance pools on their own, because we know half of all Americans work for small businesses, and many don't have a plan through their employer, and that will be included in our legislation.

Mr. DENT. And that is a very important point. You know, there are so many people out there who need coverage, and there are so many things we can do to help. You just mentioned the idea of allowing employers to reach across State lines and realize greater discounts. That is critical.

But the other issue, too, to help the uninsured, we know that employers receive favorable tax treatment. They get a tax exclusion that is very beneficial to helping them provide health care coverage to their employees. That is a good thing. We want to protect that. There are about 165 million Americans that have health care through their employers in many respects, and what we should do is give the individual who lacks insurance, if his employer cannot provide it to them or if they are self-employed or on their own, give them the opportunity to buy health insurance and give the same kind of favorable tax treatment to the individual that we currently give to the business. That would do a lot to help cover particularly that younger population that is relatively healthy and insurable.

Mr. TIM MURPHY of Pennsylvania. In addition to that, it has to do with how they purchase it. The Federal Government recognizes that if we allow people of low income to pool together they can negotiate better prices. The VA does this all the time. They combine the purchasing power of the VA to purchase for veterans across the Nation. Yet we don't let individuals do that.

We don't let a small business that only has half a dozen employees or 20 or 50 employees to join other businesses of the same type, and that wall placed by insurance companies and by the government leads to higher costs. We ought to allow businesses to do the same thing the Federal Government does and use that as a mechanism to drive down costs substantially.

Mr. KIRK. One of the things that you have put forward, Congressman MURPHY, is the need for public health clinics, et cetera. I think that puts forward a critical point right now missing in the debate.

We know that of the uninsured, by this estimate 44.7 million, of the uninsured, currently 14.7 million are already eligible for public coverage.

Mr. DENT. That would be Medicaid and SCHIP.

Mr. KIRK. That is right, Medicaid, SCHIP and other State programs. But as we found in the State of Massachusetts, when a mandate that everyone has to buy health insurance is put forward, what they have generally found is that a technical and legal solution is not adequate.

They thought that by putting a health insurance signup machine at the entrance of every emergency room in the State they would register and collect the required number of people who hadn't yet signed up for the public assistance that they were eligible for.

What they found is, for a small percentage of the most difficult patients, either because of alcohol, drug abuse or law enforcement problems, these patients were not registering under similar names, not registering under similar addresses, and were failing to report for appointments and other preventive care, meaning for that very small percentage of Americans, we need to provide an open public clinic.

It is the much-more appropriate health delivery system than an insurance system, because for this small group of Americans we have different names, different addresses and different lifestyles, and yet we still want to provide care. But having a 100 percent insurance mandate didn't do it. You needed to do it through a public health clinic.

Mr. TIM MURPHY of Pennsylvania. And as you described, it brings the thought too that in addition to people having this hodgepodge of how disjointed a difficult system that does not allow individuals or employers to purchase insurance is, we oftentimes look upon other solutions and think, well, they are not purchasing it for other reasons, and we artificially keep those things high, and we keep a system that also incentivizes lots of tests, we incentivize a system that is really dysfunctional.

In that I bring to my colleagues' attention an article published by the New England Health Care Institute that said out of this $2.4 trillion health care system, this Nation wastes about $700 billion a year, and all these inefficiencies have to do with care delivery, even beyond that of what we are talking about here, with the tax, the incentives, the insurance and barriers we set up too.

Mr. KIRK. One of the things that we want to make sure is sometimes in this debate when you hear about the uninsured, you may have the impression that the Federal Government doesn't spend any money already providing health care to low-income and needy Americans.

As this chart, already somewhat outdated from 2004 shows, it is a total of almost $35 billion in assistance given to cover the uninsured. But one of the problems has been that some of the patients directly eligible for these government programs don't sign up.

Mr. DENT. The gentleman, Mr. KIRK from Illinois, pointed out an interesting point. He mentioned the Massachusetts health care experiment. What they did in Massachusetts, they had a universal mandate for coverage, but they did not do anything to deal with the cost issue.

So what happened in Massachusetts is while the numbers of those who were being provided coverage through the various programs in Massachusetts through the mandates, those costs rose, but the ability of the taxpayers to meet those rising costs, of course, was limited. So what does the government do? It restricts care, it denies treatment, it denies service, it rations care. That is sort of a microcosm in Massachusetts of what happens in perhaps some other Western European countries or perhaps even Canada.

I am not here to either praise or condemn those systems in Western Europe and the United Kingdom or in Canada or anywhere else. They are different systems. And people need to understand that what happens in those systems when the costs continue to rise for health care and there aren't the tax dollars to meet those costs, they deny care. I think we all know that people are concerned about cures and not treatments. They want to be treated like human beings and not numbers.

Unfortunately, that can happen in those systems where you have a single-payer system. You take a number, wait for your dialysis, wait for your hip replacement, if you can wait that long. If you are a Canadian, if you have the money, you come across the border and get the care you need when you need it. We need to have this very sober discussion.

Mr. KIRK. By the way, the gentleman points out Canada, a country that has basically a two-tier health care system, the Canadian health care system, and then when you are denied care, which is especially prevalent in any care needing advanced imagery or new oncology medicines to fight cancer, the relief valve is they come to the United States. Some Canadian doctors call it ''Fargo-ing a patient,'' meaning when a patient is denied care or care is going to be tremendously delayed under the Canadian system, they will then refer that patient to Fargo, North Dakota, where they will immediately get care under the U.S. system.

The concern I have though is if we have the government take over health care, where will we be able to drive? Where will we be able to go? That is why in our legislation that we will be outlining on Tuesday, it includes the Medical Rights Act, and the Medical Rights Act says this: We guarantee the right of patients to carry out the decisions of their doctors without delay or denial of care by the government.

The legislation protects the right of each American to receive medical services as deemed appropriate by their doctor.

Mr. TIM MURPHY of Pennsylvania. Let me add to that. That is a great base to be moving from that what they do there does need to be these basic rights outlined, because we have a system that stands with huge barriers between doctor and patient and much of that barrier is the government.

The government through Medicare and Medicaid, for example, handles cost controls by delaying care, by denying care and by denying or diminishing payment. So physicians and hospitals that are paid, for example, 30 or 40 percent less for Medicare services, or saying you are not allowed to do these other tests, we are not going to pay for it, end up promoting a situation that is more based on quantity than quality, and that actually increases many costs and increases the chances for fraud and abuse. In Pennsylvania, there was news in the paper of just millions of dollars again of abuse in this system.

What is so important is if you have the patient and the doctor in charge of their care, you incentivize quality, you make sure the doctor has timely information through electronic medical records, et cetera. Those are important things which we are not doing yet as part of this.

But then you look at other clinics, you look at a Mayo Clinic, you look at the Geisinger Plan, you look at the University of Pittsburgh Medical Center, ones that have really focused on, We are going to change the quality and delivery of care and focus on outcome—you actually see those costs go down. That is part of the focus we need to have.

With that, I yield back to my colleague.

Mr. KIRK. Let me just follow up. I want to talk about some of the solutions we are going to put forward, because what is lost sometimes in this debate is we agree with the President that we should lower costs. We agree with the President that we should expand health care. But we think we have a better way.

Many times in partisan debate people can say that we have no alternative. So we have spent about 90 percent of our time coming up with that alternative. We want to make sure that we guarantee the rights of each patient in the doctor-patient relationship so that you or a loved one in your family is allowed to carry out the decisions made by you and your doctor and not be interfered with by a government bureaucracy.

Also though we are focusing in our legislation coming up on lowering the cost of insurance through alliances, through equalizing the tax benefit for individuals so they get the same benefit that employers get when they buy health insurance, and obviously what we have talked about here, lawsuit reform.

Mr. DENT. That was the point I made a few moments earlier about equalizing the tax treatment. That is a point we are stating; that the 165 million Americans—I think that is about 60 percent of our population—has insurance through their employers, but those individuals who cannot afford insurance, and there are a lot of them out there, unfortunately, cannot afford their insurance, but they get no favorable tax treatment themselves. Their employer receives it, as they should, that treatment, but the employee, the worker or the self-employed individual should get that same favorable treatment.

That is a way to really help particularly the younger population, some of whom have some capacity to purchase insurance. They may be relatively healthy, but they choose not to purchase it. Some use the term ''the invincibles.'' Obviously they are not. But they need insurance, and we can help that population afford a reasonable, comprehensive plan.

□ 1915

And that's one of the major parts of the reform that you and I have worked on. And I think we can do this in a bipartisan manner. I think there are plenty of people in this room, on both sides of the aisle, that would be willing to vote for this type of commonsense reform that's going to help people get access to care and coverage.

Mr. KIRK. And here's what we've been working on. We want to equalize the benefit so that if you buy your own insurance, you get the same tax benefit that an employer gets when it buys for employees.

But here's what I'm concerned about. There are ideas building in strength now, in the Congress and downtown, that talk about cutting the tax benefit that employers get for providing health insurance to their employees.

One study by the Llewellyn Group says that if that tax break that employers get for providing care to their employees is cut, 100 million Americans will lose their health insurance. And so a health reform bill, ironically, will cut the number of Americans who have their own insurance from 170 million to 70 million.

Our bill, our positive alternative, goes in exactly the opposite direction. We're enhancing employer-provided coverage and making sure that it's more available.

But I yield to the gentleman.

Mr. DENT. That's an astounding statistic from the Llewellyn Group. When you talk about 100 million Americans potentially losing their health care, where will they go to get it? That's really the issue. So that employer exclusion, that favorable tax treatment is absolutely essential to making sure that many Americans are able to maintain their coverage. And that's the first thing we have to protect in this whole discussion. We have to protect that first.

And some of the proposals that are floating around this capital, as you correctly pointed out, would either eliminate that exclusion or severely limit it as a way to finance whatever kind of program they're advancing. And this is big money.

So I just wanted to share that with the American people, make sure they understand that that seems to be the primary funding mechanism that many are looking at to finance whatever kind of health care system would be proposed, whether it's a government option or some other proposal, single-payer. That's something to be concerned about.

Mr. KIRK. That's what we worry about. They're talking about maybe a $1 trillion cost of a government plan. And so the most obvious response with such a cost is a huge income tax increase, but we know most Americans oppose that.

Some, including Ezekiel Emanuel, one of the heads of the President's advisory committee, has talked about a national sales tax on top of the other tax, but I think there's significant opposition to that. So they've talked about cutting back on the tax benefit that employers get when they provide health care to their employees, but by this estimate, it could cost over 100 million Americans their health insurance.

I yield to the gentleman.

Mr. TIM MURPHY of Pennsylvania. As that goes, when we look at the government running a plan that costs $1 trillion, that's several hundred billion more than the Pentagon. And I'm not

sure that people would say the Pentagon, for all the pride we have of all our soldiers, our sailors, our airmen and marines, I doubt that people would say that's the model of economic efficiency.

Would they say that Social Security run by the Federal Government is the best investment system? Would they—I mean, pick a system that the Federal Government runs, and it's hardly seen as the best. We know we have a lot of dedicated employees there, but oftentimes they are saddled and handcuffed by regulations.

We have a system that is still, after all these years, Medicaid, that has been around since the 1960s, so fraught with inefficiency that it invites waste, fraud and abuse. It has not been revamped.

An article that appeared in the New England Journal of Medicine a couple of weeks ago by Victor R. Fuchs was saying we've got to fix this system first; otherwise—and I go back to this article from the New Yorker. It says this: Providing health care is like building a house. The task requires experts, expensive equipment and materials, and a huge amount of coordination. Imagine that, instead of paying a contractor to pull a team together and keep them on track, you paid an electrician for every outlet he recommends, a plumber for every faucet and a carpenter for every cabinet. Would you be surprised if you got a house with 1,000 outlets, faucets and cabinets at three times the cost you expected, and the whole thing fell apart a couple of years later?

That's where we are with our health care system. It must be focused on quality and on outcome. And I worry that if we have a government-run system and this bureaucracy created, it's going to be a matter between you and your doctor and this Congress. To get anything done, it's going to take an act of Congress or bureaucracy. That's going to be such a huge cost on top that all the people will say, well, it's going to be less involved with regard to administrative cost. I don't see how that is possible, given the track record we have.

Mr. KIRK. If the gentleman will yield, we also not only see other examples of the government poorly running the bureaucracies that it already has taken over, but recently the government took over the largest bond dealer, Bear Stearns. The government has taken over the largest insurance company, the American International Group, and the government has taken over the largest car manufacturer, GM. And I don't think that any us of would argue that the government is running it better in their current states.

Mr. DENT. And if the gentleman would yield, to follow up on that point you were just making about government ownership and autos and financial services and elsewhere, let's talk a moment about health care. And there's an idea being floated about called a government option, which needs to be, I think, fully understood and vetted before the public. But that government option many fear may become the only option for insurance because a government option coverage perhaps would be able to offer it at a much lower cost than any kind of a private sector insurance product. And the fear is that you would have a backdoor government takeover of our health system through this government option, a very real concern.

And again, I just don't think that we should lose sight of the fact that if we—this turns into a backdoor, single-payer system or a government takeover of health care, what will soon follow will be rationed care, that is, waiting lines, delays, denials of care.

Mr. KIRK. I want to emphasize the point the gentleman raises. Not only, if we create a government health care program, will it compete and may be the lowest cost option because it has a taxpayer subsidy, but that taxpayer subsidy may be paid for by ending some of the tax break that employers have in providing health care to their employees.

Mr. DENT. 165 million Americans.

Mr. KIRK. Right. And so, employers seeing that they don't get a tax break anymore for giving health care to their employees will simply cancel your health insurance program, and then the government will be your only option.

Mr. TIM MURPHY of Pennsylvania. As this goes, I mean, I believe the government does have a role in terms of providing regulations, standards of clinical excellence, and pushing companies toward this constantly. Provide the oversight that says, if you're going to be spending the taxpayers' money on Medicaid, Medicare and the VA, we want to see quality measures.

So, if the Federal Government's going to put up money for electronic medical records, to say we need to see you driving constantly towards interoperability, towards intelligence systems, towards integrated systems, towards ones that are highly interactive with the physician. If the Federal Government can play a role in pushing people towards higher quality, I worry if the Federal Government is the prime owner of this, will the Federal Government, itself, push things towards that, and that's were I have trouble reckoning that.

Mr. KIRK. I am going to keep this on the positive side because what we're doing is we're putting together a positive alternative. And one of the other reforms that we will be outlining is to dramatically expand the number of Americans who can have a health savings account, very much like an IRA, so that they can save, especially in their younger, more healthy years, in a tax deferred account that they will use to make up for their deductible expenses and their health insurance.

Over time, as with our IRAs, an account balance will build up. And then, if each of us reaches the age of Medicare, at 65, with a balance in that account, that account either can become part of our retirement plan or eventually a part of our estate to our children.

This is a much more flexible way of providing health care and, more importantly, it's owned by you, not by a government bureaucracy.

I yield to the gentleman.

Mr. DENT. Well said. And I think we should focus on solutions. We've talked a lot about the challenges and the problems and the costs, but it does come down to solutions. And I think to sum up what we've been talking about tonight in terms of our solutions, you, Congressman KIRK, have been a great leader on the Medical Rights Act. And to make sure that that sacred relationship between doctor and patient is not violated, we have to protect that principle, and that notion must be protected up front.

As we lower the cost of insurance, we've talked about some ideas about making sure that businesses can reach across State lines, they can reach across State lines, realize greater discounts so they can provide more affordable coverage to their employees. That's a cost issue.

Medical liability reform, and we've given some specific examples of things we can do on medical liability reform to help lower the cost of care. Absolutely critical.

We want the States to be innovative. We want them to be innovative. And many States, I believe 34 States, have high risk pools, some of which work reasonably well, and others are not very effective. And so how can we help States innovate, to provide ways to make sure people receive coverage, particularly that uninsured population I think we're all generally concerned about. That's that population that is chronically uninsured, and maybe it's about 10 million people. I don't have the statistics in front of me, but somewhere around 10 million people are chronically uninsured. They're not that under-35 population, but people who really need help and may have a preexisting condition that prevents them from getting picked up. Or a person, right now, let's face it, a lot of people are more—what they're afraid of more than losing their jobs is losing their health care coverage. And I think we have to make sure that we take care of that population, uninsured who have a preexisting condition. We need to help them, particularly if they're high risk. And that's where we can use the States, I think, to be very, very innovative.

And the other thing that we have to talk about too, and we don't talk enough about it, but I think people want to see medical breakthroughs in the United States. They want quality and they want innovation, and they don't want an average system.

And I've always been struck. I visited the country of Ecuador once with my family a few years ago, and I was

struck. The tour guide was telling me about their national system, and then we drove by the hospitals. They're right next to each other, the public hospital and the private hospital, and you could tell which was which visually. The private hospital looked like a hotel, a very inviting place. The public hospital, unfortunately, looked like a building that was somewhat dilapidated. And that's what just frightened me, two tiers of care. Now, this is a Latin American country. Some might call it a third world country. But nevertheless, that's what I saw, and I would never want to see that happen in America.

Mr. KIRK. If the gentleman would yield. What you heard tonight is focusing on positive outcomes, making sure we reform health care, less defensive medicine, deploy health information technology, health individual savings accounts.

We have spent far less time criticizing the President and far more time outlining a new positive agenda. But to close tonight, I'd like to turn to Dr. MURPHY, who's been more in the health care system than all of us, to finish us out.

Mr. TIM MURPHY of Pennsylvania. When I look at this, I want Americans and all of us to imagine a system that's based upon cures and based upon outcome, a system where doctors are in charge of your health care, not insurance companies, not the government. And I know that both sides of the aisle are deeply concerned about this. It is not that one side or the other wants insurance companies or the government to win. We all want patients to win, Democrats and Republicans alike. But we must have a system that's focused upon this, not that creates incentives because we're paying people so low to do more and more tests, not to promote more and more medical procedures, but to really focus on this outcome. We can do this through these things we're doing, the patient and doctor in charge. Don't create more barriers. Make sure we have all the efficiency there for quality. We can do those things. Imagine what can happen. Imagine the possibilities. And let's just not throw it out and say it's too difficult; let the government run it.

With that, I yield back to my colleague, Congressman DENT.

Mr. DENT. Just in conclusion, I just think we want to say a few things. I think in our health care system we certainly want our system to be focused on prevention, not maintenance. We want cures, not treatments. The system should be about doctors, not lawyers. We want patients to be treated like they want to be treated, like human beings. They want to be treated like people and not some number, something abstract. They want to be treated like a human being.

And so, because at the end of the day, we all want our loved ones to be cared for. You don't want them to have to wait. You don't want to see your mother, like mine, who's 80 years old be told that she's contributed her whole life, relatively healthy, we don't want to tell her, I'm sorry, we're going to discard you now that you've reached a certain age. That's what we are concerned about.

So we're going to try to work, I think, in a bipartisan manner, try to work in a way that embraces a lot of ideas that we can all share. And short of a government takeover of our system, I think we can do that. We have the capacity to do it. The American people expect it of us, and I look forward to working with all my colleagues to come to that kind of result.

Mr. KIRK. I thank the gentleman, and we will be outlining a positive set of reforms that we think can attract tremendous bipartisan support this Tuesday, from the centrists.

Mr. PETRI. Mr. Speaker, today, President Obama is in my home state of Wisconsin conducting a town hall meeting to promote his health care agenda.

I know that the residents of my home state will tell him that they are struggling to keep up with the rising cost of their health care premiums, while others are simply unable to afford health care coverage.

Many people in my state have lost their jobs and fear that they won't be able to afford their children's medication or that an unforeseen illness will bankrupt them.

Some individuals who have insurance are simply staying in a job they don't like because their next job may not offer health care insurance.

Others who are happy with their insurance worry that any drastic reform will force them into a system that will limit their choice of doctor or access to medical treatment.

I agree with the President that it is time to fix the health care system in the United States so that all Americans, all my constituents, have access to quality affordable health care coverage.

However, I strongly believe that any reform that we consider in the House must be based on a few important principles.

First, it must give everyone access to quality and affordable health care.

All individuals should have the freedom to choose the health plan that best meets their needs.

Second, any reform should ensure a patient centered system.

Patients in consultation with their doctors should be in control of their health care decisions and not government bureaucrats or insurance agents.

If your child or parent is sick, you should have access to timely tests and treatments and not subject to waiting lists or treatment decisions dependent on anyone other than you and your doctor.

Third, our health care system must emphasize prevention and wellness.

Chronic diseases account for 75 percent of our nation's medical costs. By implementing programs focused on preventing such things as smoking and obesity-related diseases, we will not only save lives, but reduce health care costs.

And lastly, any reform needs to focus on getting rid of the waste, fraud and abuse that plagues our current system. Approximately $60 billion is lost due to fraud in the Medicare program alone. We can't afford to multiply that number through a government takeover of our entire health care system.

Our health care system needs to prioritize efficiency, transparency, and results.

I look forward to working with Members of both parties to ensure that these principles guide any legislation we will consider in the future.

GENERAL LEAVE

Mr. KIRK. Mr. Speaker, I would like to ask unanimous consent that Members have 5 legislative days in which to revise and extend their remarks on the subject of my Special Order.

The SPEAKER pro tempore (Mr. BRIGHT). Is there objection to the request of the gentleman from Illinois?

There was no objection.

HEALTH CARE REFORM

The SPEAKER pro tempore. Under the Speaker's announced policy of January 6, 2009, the gentlewoman from Pennsylvania (Ms. SCHWARTZ) is recognized for 60 minutes.

Ms. SCHWARTZ. Mr. Speaker, I rise this evening to begin what I hope will be a Special Order time with my colleagues. It's a little earlier than we thought, so we're going to see as they make their way to the floor. Hopefully they will be joining me.

But, as you know, there has been a great deal of discussion about health care reform. We just heard a Special Order now from my colleagues on the other side of the aisle talking about health care reform and some of their thoughts about it, and I think sometimes we focus very much on controversial issues and some of the difficult decisions we have to make as we move forward, and let me start with what we're trying to do on health care reform, on this.

What we want to talk about tonight is some of the very important work we want to do as we really meet the President's goals.

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He has laid out to us the goals for health care reform, and they are really threefold. They are to make sure that we contain costs. The fact is that our businesses have said to us that the high cost of health coverage, providing health benefits for their employees, has gone up almost double digits every year. And what that really means is that we have doubled the cost of health care benefits to our companies in the last 10 years. That's unsustainable for our businesses, whether they are small businesses that are trying to be economically competitive in their communities or very large businesses that are really functioning on the global marketplace and really competing with companies that are in countries where health care is not an individual employer's responsibility and where costs are more controlled. So we know it's